MDR: M4-02-2019-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for date of service 8-6-01.
   b. The request was received on 2-13-02.

II. EXHIBITS

1. Requestor, Exhibit I:
   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92s
   c. EOBs
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:
   a. Response to a Request for Dispute Resolution
   b. ASC Payment Groups, *Federal Register 12/14/93*
   c. Wage Index Sheet
   d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 6-27-02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 7-1-02. The response from the insurance carrier was received in the Division on 7-11-02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 6-12-02:
   "(Claimant) came into …. for surgery on his shoulder. We performed this surgery in good faith we would get paid a fair and reasonable amount for his service. The total charge on the claim is $9381.10 and we received a payment in the amount of $922.00…I have attached an explanation of benefits (EOB) from …. for the same procedure for a different patient. Payment received on this claim was $9,538.56 which is a fair and reasonable amount."

2. Respondent: Letter dated 7-11-02:
   "The requester believes it should be paid more but offers no rational explanation why other than to

state that other carriers reimburse it a high percentage of billed charges.…In the public comments to rule 134.401 the Commission described its analysis of cost-based models of reimbursement and its reasons for rejecting these with respect to hospital reimbursement, the principal one being that a hospital's costs cannot be verified….(Respondent) established and explained its method of determining fair and reasonable reimbursement, consistent with 133.304 (i), as well as 133.307 (j)…(Respondent) used data from two national resources 1) ASC charges as listed by CPT code in '1994 ASC Medicare Payment Rate Survey,' and 2) ASC Group payment rates as determined by the Secretary of the U.S. Department of Health and Human Services for surgical procedures by CPT code."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 8-6-01.

2. The carrier denied the billed services as reflected on the EOB as, "M – THE REIMBURSEMENT FOR THE SERVICE RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B);" "OPSR – M – FAIR AND REASONABLE REIMBURSEMENT FOR THIS ENTIRE BILL IS MADE ON THE 'OR SERVICE' LINE ITEM."

3. The Requestor billed the Respondent $9,381.10.

4. The Respondent paid $922.00.

5. The Requestor is seeking additional reimbursement of $8,459.10.

6. The services provided by the Requestor include such items as anesthesia and lab services, pharmaceutical products, medical and surgical supplies, sterile supplies and EKG.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. The provider has submitted additional reimbursement data: one example EOB for charges billed for a similar procedure.

However, the carrier has submitted documentation asserting that they have paid a fair and reasonable reimbursement. Respondent has submitted a copy of their payment methodology.

Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

3. reference its method in the claim file; and

4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;"

The carrier asserts that EOBs do not constitute a pattern substantiating fair and reasonable; and likewise, the requestor's example EOB does not refute that the Respondent has developed and consistently applied it's methodology to determine fair and reasonable.

The Respondent indicates that Medicare classifies surgical procedures into 8 groups. All CPT Codes within the same grouping are paid at the same rate (group rate). That reimbursement allowed by Medicare is then multiplied by 20%. This is the copay amount under Medicare that the patient pays and which is not allowed by The Texas Workers' Compensation Act. The group rate and the copay amount are added together to determine the total payment.

Regional and geographic differences are taken into account by Medicare. However, the Carrier believes that by taking the group rate and adding in the copay amount, that its reimbursement offsets any regional or geographic differences in wage adjustment.

The Respondent has submitted additional information to further support its methodology. Exhibit 1 is a copy of the ASC groups as indicated by the Federal Register, 12/14/93. Exhibit 2 is a list of various CPT Codes and the Group under which it falls.

Due to the fact that there is no current fee guideline for ASC's, the Medical Review Division has to determine, based on the parties' submission of information, who has provided the more persuasive evidence. As the requestor, the health care provider has the burden to provide documentation that "…discussed, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement…." pursuant to TWCC Rule 133.307 (3) (g) (D). While the requestor has attached a copy of one example EOB, they have failed to demonstrate how this documentation is utilized in their determination of the amount billed. Respondent has provided their methodology which conforms with the additional criteria of Sec. 413.011 (d),

The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence. In this case, the Requestor has failed to support their position that the amount billed is fair and reasonable and the Respondent has submitted enough information to support the argument that the amount reimbursed represents a fair and reasonable reimbursement. Therefore, **no additional** reimbursement is recommended.

REFERENCES: The Texas Workers' Compensation Act & Rules: Sec 413.011 (d); Rule 133.304 (i); Rule 133.307 (g) (3) (D); and (j) (1) (F).

The above Findings and Decision are hereby issued this 4th day of February 2003.

Lesa Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll